STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154021	A. BUILDING **01 - GRANT BLACKFORD MENTAL HEALTH** B. WING _____	R **10/29/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRANT-BLACKFORD MENTAL HEALTH, INC	**505 WABASH AVE** **MARION, IN 46952**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Post Survey Revisit (PSR) to the Life Safety Code Validation Survey conducted on 06/25/14 was conducted by the Indiana State Department of Health in accordance with 42 CFR 482.41(b). Survey Date: 10/29/14 Facility Number: 005964 Provider Number: 154021 AIM Number: 100273390A Surveyor: Dennis Austill, Life Safety Code Specialist, At this PSR survey, Grant-Blackford Mental Health, Inc. was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 482.41(b), Life Safety From Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and Chapter 39, Existing Business Occupancies. This two story facility with a lower level was determined to be of Type II (222) construction and was partially sprinklered. The lower level was sprinklered with the main floor and inpatient floor being nonsprinklered. The facility has a fire alarm system with smoke detectors on all levels throughout the corridors. The Lower Level and Main floor were surveyed as Business Occupancies and the Upper Level was surveyed as a Healthcare Occupancy. The facility has a capacity of 16 beds and had a census of 4 at the time of this survey.	{K 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	154021	A. BUILDING **01 - GRANT BLACKFORD MENTAL HEALTH** B. WING _____	R **10/29/2014**

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{K 000}	Continued From page 1 Quality Review by Lex Brashear, Life Safety Code Specialist-Medical Surveyor on 11/03/14.	{K 000}		